	MENT OF UEALTH	AND HUMAN SERVICES			٢١		U7/U6/ZU18 APPROVED
		& MEDICAID SERVICES			0		0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01		SURVEY PLETED
		445154	B. WING				02/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
QUALITY	CENTER FOR REHA	BILITATION AND HEALING LLC			2 BADDOUR PARKWAY EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
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	State of Tennessee Division of Health L Office of Health Car During this Life Safe Rehabilitation and I- substantial complian participation in Med Subpart 483.70(a), related National Fire (NFPA) standard 10 The requirement at is NOT MET as evice *** A follow up visit or revealed Quality Ce Healing was found in requirements for pa Medicare/Medicaid Life Safety from Fire	42 (CFR), Subpart 483.70(a) denced by: conducted on 6/5/2018, enter for Rehabilitation and in compliance with					
	g						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

		AND HUMAN SERVICES				APPROVED 0938-0391	
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	TIPLE CONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN C	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		ING 01 - MAIN BUILDING 01	COMF	MPLETED	
					F	₹	
		445154	B. WING		07/0	2/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
OHALITY	CENTED FOR REHA	BILITATION AND HEALING LLC		932 BADDOUR PARKWAY			
QUALITI	CENTENTONNELIA	BILITATION AND TIEXELING 220		LEBANON, TN 37087			
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PRINTED: 07/06/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION (AT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		445454	B. WING			R
	PROVIDER OR SUPPLIER	445154 ABILITATION AND HEALING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087	07/	02/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{K 000}	Continued From pa	age 2	{K 00	90}		
	07/02/2018 for all p 06/05/2018. All def corrected, and no r	survey was conducted on previous deficiencies cited on ficiencies have been new noncompliance was found. In a surpliance with all regulations				

Quality Center Jun. 13. 2018 3:07FM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES No. 4773

FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED-

06/05/2018

(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

445154

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER!

STREET ADDRESS, CITY, STATE, ZIP CODE

932 BADDOUR PARKWAY

QUALIT	Y CENTER FOR REHABILITATION AND HEALING LLC	i	LEBANON, TN 37087	*****************************
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
{K 000}	INITIAL COMMENTS	{K 000}		
	A Life Safety Code Survey was conducted by the			

State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/30/2018. During this Life Safety Survey, Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.

The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:

** A follow up visit conducted on 6/5/2018, revealed Quality Center for Rehabilitation and Healing was found in compliance with requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

if continuation sheet Page 1 of 1

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

May. 23. 2018 2:03PM Quality Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 4309 F. 41 PRINTED: 05/03/2018 FORM APPROVED OMB NO. 0938-0391

Addity Centre For Rehabilitation and Healing Lic (X3) ID (X4) ID (X5) ID (X6) ID (X6) ID (X7) ID (X6) ID	STATÉMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
ALIFE Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Correction and Healing was found not in substantial compliance with the require which related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR) Subpart 483.70(a) is NOT MET as evidenced by its NOT MET as evidenced by the State of Tennessee Department of Health Division of Health Corrective Action. The trash-car, bicycle and shop-vax were removed from the path of agrees. The linear carried width of the corridor. Subpart 483.70(a) is NOT MET as evidenced by: K 232 Asile, Corridor, or Ramp Width CFR(s): NFPA 101 Asile, Corridor or Ramp Width 2012 EXISTING The width of alsiles or corridors (clear or unobstructed) severing as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the asile, corridor or ramp width. The findings included: 1. Observation on 04/30/2018 at 9.41 AM, revealed a trash card stored in the means of egress on the side of the exit by loom 133. NFPA 101, 19.2.3.4* (2012 Edition)			445154	B. WING	_		04/3	80/2018
Recommendation Property Pro					93	2 BADDOUR PARKWAY		
A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/30/2018. During this Life Safety Survey, Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a). Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: X 232 Aisle, Corridor, or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 4-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the aisle, corridor or ramp width. The findings included: 1. Observation on 04/30/2018 at 9:41 AM, revealed a trash cart stored in the means of egress on the side walk outside of the exit by room 133. NFPA 101, 19.2.3.4* (2012 Edition)	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	- 10	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	BE	COMPLETION
State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/30/2018. During this Life Safety Survey, Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a). Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: K 232 Asile, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor, or Ramp Width 2012 EXISTING The width of aisless or comidors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the aisle, corridor or ramp width. The findings included: 1. Observation on 04/30/2018 at 9:41 AM, revealed a trash cart stored in the means of egress on the side walk outside of the exit by room 133. NFPA 101, 19.2.3.4* (2012 Edition)	K 000	¥		K	000			
egress on the side walk outside of the exit by room 133. NFPA 101, 19.2.3.4* (2012 Edition) effective and if any further corrective action is warranted.		State of Tennesse Division of Health Office of Health Couring this Life State and Interest of the State of Health Couring this Life State of Health Couring this Life State of Health Couring the Substantial compliparticipation in Mesubstantial compliparticipation in Mesubstantial Formal Fo	the Department of Health Licensure and Regulation Care Facilities on 04/30/2018. Cafety Survey, Quality Center for Id Healing was found not in Cance with the requirements for Calciare/Medicaid at 42 CFR Calciare/Medicaid Calciare/Medicaid Calciare/Medicaid Calciare/Medicaid Calciare/Medicaid Calciare/Medicaid	K	232	 Corrective Action: The trash cart, by and shop-vac were removed from the of egress. The linen carts were moved the corridors. The ADM and/or Nur Educator inserviced the staff to ensegress paths are clear, required with the corridors are maintained and linearts are moved in the corridor so a maintain the required width of the corridor. Identifying other residents with poto be affected: The facility determines have the potential to be a Measures or Systemic Changes: The Maintenance Director or designed audit the corridors and egress point ensure the required width is maintained aily for 4 weeks and then weekly find months. How corrective action will be monified. The ADM or designed will review at reports from the Maintenance Director designee at Stand Up meetings to determine if any violations or conceiver identified. The ADM or designed monthly for 2 months. The AD designed will review the audits and findings to the QAPI committee. The committee will review the results and findings to the QAPI committee. The committee will review the results and findings to the QAPI committee. The committee will review the results and findings to the QAPI committee. The committee will review the results and findings to the QAPI committee. The committee will review the results and findings to the QAPI committee. 	icycle he path yed in rse ure lth of hen is to rtential hed all iffected he will ts to ained for 2 itored: udit ctor or erns hee will nt eks own or report he QAPI t the	5/23/18
AND DATE		egress on the side room 133. NFPA	e walk outside of the exit by 101, 19.2.3.4* (2012 Edition)	77		effective and If any further correcti action is warranted.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Administrator

No. 4209 F. 42 PRINTED: 05/03/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 04/30/2018 B. WING 445154 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 932 BADDOUR PARKWAY QUALITY CENTER FOR REHABILITATION AND HEALING LLC LEBANON, TN 37087 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) 1AG TAG DEFICIENCY) K 232 K 232 Continued From page 1 2. Observations on 04/30/2018 between 9:43 AM and 10:48 AM, revealed the linen carts stored in the corridors in the following locations: a. By room 130 5/23/18 b. By room 140 c. By room 121 K234 - Cooking Facilities d. By room 105 Corrective Action: The deep fat fryer was e By room 114 centered under the hood suppression By room 90 nozzle. The ADM and/or Nurse Educator NFPA 101, 19.2,3.4* (2012 Edition) inserviced the kitchen staff to ensure the cooking equipment was kept under the 3. Observation on 04/30/2018 at 10:17 AM, hood suppression system and centered revealed storage of a bicycle and shop-vac in the underneath appropriately. means of egress outside of the exit by room 109. Identifying other residents with potential NFPA 101, 19.2,3.4* (2012 Edition) to be affected: The facility determined all residents have the potential to be affected. Maintenance staff was present when these Measures or Systemic Changes: The deficiencies were identified and the Administrator Maintenance Ofrector or designee will acknowledged these deficiencies during the exit audit the cooking equipment dally for 4 conference on 04/30/2018. weeks and then weekly for 2 months to K 324 Cooking Facilities K 324 ensure cooking equipment is kept CFR(s): NFPA 101 SS=D centered under the hood suppression Cooking Facilities How corrective action will be monitored: Cooking equipment is protected in accordance The ADM or designee will review audit with NFPA 96, Standard for Ventilation Control reports from the Maintenance Director or and Fire Protection of Commercial Cooking designee at Stand Up meetings to determine if any violations or concerns Operations, unless: were identified. The ADM or designee will residential cooking equipment (i.e., small complete an audit form to document appliances such as microwaves, hot plates, findings of reviews weekly for 4 weeks toasters) are used for food warming or limited then monthly for 2 months. The ADM or cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 designee will review the audits and report * cooking facilities open to the corridor in smoke findings to the QAPI committee. The QAPI, compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective * cooking facilities in smoke compartments with action is warranted.

No. 4309 F. 42/50 PRINTED: U5/U3/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE ING 0	CONSTRUCTION 1 - MAIN BUILDING 01	COMPLETED
8		445154	B. WING			04/30/2018
NAME OF F	ROVIDER OR SUPPLIER		8		REET ADDRESS, CITY, STATE, ZIP CODE	
QUALITY	CENTER FOR REHA	BILITATION AND HEALING LLC			2 BADDOUR PARKWAY BBANON, TN 37087	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI * TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLETION DATE
K 232	·	, r	K2	232		1
83	and 10:48 AM, reve the corridors in the a. By room 130	04/30/2018 between 9:43 AM ealed the linen carts stored in following locations:			24	
	b. By room 140 c. By room 121 d. By room 105 e. By room 114 f. By room 90 NFPA 101, 19.2,3.4	(* (2012 Edition)			 K234 - Cooking Facilities Corrective Action: The deep fat fryer wa centered under the hood suppression nozzle. The ADM and/or Nurse Educator inserviced the kitchen staff to ensure the 	r
	revealed storage of means of egress of NFPA 101, 19.2.3.4				cooking equipment was kept under the hood suppression system and centered underneath appropriately. 2. Identifying other residents with potentiable affected: The facility determined	tal ali
K 324 SS=D	deficiencies were id	was present when these dentified and the Administrator se deficiencies during the exit 80/2018.	К	324	residents have the potential to be affect Measures or Systemic Changes: The Maintenance Director or designee will audit the cooking equipment daily for 4 weeks and then weekly for 2 months to ensure cooking equipment is kept centered under the hood suppression	
	with NFPA 96, Star and Fire Protection Operations, unless	t is protected in accordance indard for Ventilation Control of Commercial Cooking			system 4. How corrective action will be monitore The ADM or designee will review audit reports from the Maintenance Director designee at Stand Up meetings to determine if any violations or concerns	ог
- - -	* residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities compartments with	g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3,			were identified. The ADM or designee complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM of designee will review the audits and repfindings to the QAPI committee. The Quantities at the committee will review the results at the	or port DAPI
9	or cooking facilities	in smoke compartments with			QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	=

PRINTED: 05/03/2018 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 101 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445154	B, WING		04/30/2018
	PROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC	9	STREET ADDRESS, CITY, STATE, ZIP CODE 332 BADDOUR PARKWAY LEBANON, TN 37087	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	JEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
K 324	30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	s comply with conditions under 6.4. rotected according to NFPA 96 quired to be enclosed as out shall not be open to the	K 324		
	18.3.2.5.1 through 19.3.2.5.5, 9.2.3, T	18.3.2.5.4, 19.3.2.5.1 through IA 12-2		k 3 45 - Fire Alarm System - Testing at Maintenance	nd 5723/18
K 345 SS=D	by: Based on observation cooking facilities The findings include Observation on 04/ the deep fat fryer without suppressions (2012 Edition) NFP Maintenance staff of deficiencies were in acknowledged these conference on 04/3 Fire Alarm System CFR(s): NFPA 101 Fire Alarm System A fire alarm system accordance with arwith the requirement Electric Code, and and Signaling Code	ed: 30/2018 at 10:11 AM, revealed ras not centered under the system. NFPA 101, 19.3.2.5.1 A 96, 12.1.2.2 (2011 Edition) was present when these dentified and the Administrator se deficiencies during the exit	K 345	 Corrective Action: The pull station in the exit by room 109 was repaired. Stations were tested by outside continue the ADM and/or Nurse Educator inserviced the staff to ensure that protections work properly and report to ADM Immediately if any pull station not operate properly. Identifying other residents with portobe affected: The facility determines dents have the potential to be a Measures or Systemic Changes: The Maintenance Director or designed viandom pull stations monthly durindrills to ensure the pull stations wo properly. How corrective action will be monitated and the ADM or designed will review at reports from the Maintenance Director designed at Stand Up meetings to determine if any violations or conceiver Identified. The ADM or designed complete an audit form to docume findings of reviews monthly for 3 in The ADM or designed will review the audits and report findings to the Quommittee. The QAPI committee we review the results at the QAPI meed ensure the POC was effective and if further corrective action is warrant. 	All pull tractor. ull to the does tential med all ffected, me will test g fire rk itored: adit ctor or erns mee will nt months. me API will ting to f any

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 4309 F. 44/50 PRINTED: 05/03/2018 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	(X3) DATE SURVEY COMPLETED		
		445154	ற். WING		04/30/2018
	PROVIDER OR SUPPLIEF	231111		STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ANAGO DEFENDENCED TO THE ADDROVE	D BE COMPLETION
K 353 SS=0	by: Based on observation and to the findings included to maintain. The findings included the findings included the sexit by room 109 of 101, 19.3.4.5.1 (2012 Edition) NF Maintenance staff deficiencies were acknowledged the conference on 04/Sprinkler System CFR(s): NFPA 100 Sprinkler System Automatic sprinkler inspected, tested, with NFPA 25, Statesting, and Main Protection System maintenance, inspecial in a sea available.	FPA 70, NFPA 72 ENT is not met as evidenced ation and testing, the facility the fire alarm system. ded: esting on 04/30/2018 at 11:38 fire alarm pull station next to the did not function properly. NFPA 012 Edition) NFPA 101, 9.6.1.3 PA 72, 14.2.1.2.2 (2010 Edition) was present when these identified and the Administrator are deficiencies during the exit 30/2018. Maintenance and Testing The Maintenance and Testing The System are and maintained in accordance a		K353 - Sprinkler System - Maintena Testing 1. Corrective Action: The sprinkler had the mirror in the dining room, room 35, 36 and 82 were replaced. Sprinkler heads were audited to ensure no cheads needed replacement. Outsicontractors were educated on the condition of the sprinkler heads an identify any out of compliance dur required inspections. ADM and/or Educator Inserviced staff on prope condition of sprinkler heads. 2. Identifying other residents with probe affected: The facility determ residents in the areas of the sprinkler heads identified as non-compliant potential to be affected. 3. Measures or Systemic Changes: Maintenance Director or designee audit sprinkler heads in random ar for 4 weeks and then weekly for 2 ADM educated outside contractor required condition of sprinkler heads	eads by ms 32, nkler other de required! nd to ing their r Nurse r otential nined all der have the. The will reas daily: months.! s on the ads and
	Provide in REMAR	RKS information on coverage for	±)(to identify any out of compliance of their required inspections.	furing

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 4309 P. 45/50 PRINTED: 05/03/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	19 LOL MEDICHITE	Q MILDIOMID OLIVIOLO			ALLO ME ALGUEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 5 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445154	B. WING		04/30/2018
	PROVIDER OR SUPPLIER	BILITATION AND HEALING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087	2
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
K 353	any non-required or system. 9.7.5, 9.7.7, 9.7.8, 3 This REQUIREMED by: Based on observationaintian the sprink The findings included the system of the dining room. NFPA NFPA 101, 9.7.5 (25.2.1.1.2 (2011 Edinical	r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tions, the facility failed to ler system. ed: 04/30/2018 at 9:49 AM, e sprinkler by the mirror in the 101, 19.3.5.1 (2012 Edition)	K 350	4. How corrective action will be monited. The ADM or designee will review acceptors from the Maintenance Direct designee at Stand Up meetings to determine if any violations or conceive were identified. The ADM or design complete an audit form to documen findings of reviews weekly for 4 weet then monthly for 2 months. The ADM designee will review the audits and if findings to the QAPI committee. The committee will review the results at QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	dit tor or ee will tks VI or report e QAPI the
	and 10:01 AM, reverooms 32 (above the 36.NFPA 101, 19.3 9.7.5 (2012 Edition Edition) 3. Observation on 0 revealed rust on the 101, 19.3.5.1 (2012 Edition) NFP	ealed paint on the sprinklers in the tv), room 35 and room 5.1 (2012 Edition) NFPA 101, NFPA 25, 5.2.1.1.2 (2011 04/30/2018 at 10:20 AM, esprinkler in room 82-B. NFPA 2 Edition) NFPA 101, 9.7.5 A 25, 5.2.1.1.2 (2011 Edition)			
K 511 SS=D	deficiencies were to		K 51	1	
Đ s	Utilities - Gas and E Equipment using ga complies with NFP	Electric as or related gas piping A 54, National Fuel Gas Code,			

CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 4309 P. 46/50 PRINTED. UD/U3/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED
		445154	B. WING		04/30/2018
	PROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 332 BADDOUR PARKWAY LEBANON, TN 37087	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
K 511	electrical wiring and NFPA 70, National installations can contact hazard to life. 18.5.1.1, 19.5.1.1, This REQUIREME by: Based on observal maintain the utilitie. The findings included Observation on 04.	d equipment complies with Electric Code. Existing intinue in service provided no 9.1.1, 9.1.2 NT is not met as evidenced tions, the facility failed to s. ed: 30/2018 at 9:40 AM, revealed	K 511	 K511 - Utilities - Gas and Electric Corrective Action: The plug on the was replaced. The ADM and/or Nut Educator inserviced the staff to ensith that plugs have the required ground on it and to notify the ADM or designmediately so repairs can be mad appropriate or removal of the equires warranted. Identifying other residents with potential to be affected. Measures or Systemic Changes: Maintenance Director or designee audit random equipment power codaily for 4 weeks and then weekly months to ensure all plugs have a polugintact. 	rse d prong gnee e if pment ctential ined all er have The will ords for 2
K 741 SS=D	sit down hair dryer. Edition) NFPA 101, 110.12 (2011 Edition) Maintenance staff of deficiencies were in acknowledged these conference on 04/3 Smoking Regulation CFR(s): NFPA 101 Smoking Regulation include not less that (1) Smoking shall be ward, or comparising combustible gases and in any other has	was present when these dentified and the Administrator se deficiencies during the exit 80/2018. Ins shall be adopted and shall an the following provisions: be prohibited in any room, ent where flammable liquids, or oxygen is used or stored azardous location, and such ad with signs that read NO	K 74	4. How corrective action will be mor The ADM or designee will review a reports from the Maintenance Dire designee at Stand Up meetings to determine if any vlolations or conduction were identified. The ADM or designee an audit form to docume findings of reviews weekly for 4 withen monthly for 2 months. The Adesignee will review the audits and findings to the QAPI committee. To committee will review the results QAPI meeting to ensure the POC will be defective and if any further correct action is warranted.	ector or control of the control of t

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 4309 P. 47/50 PRINTED 05/03/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR WEDICANL	A WILDIGAID OLIVIOLO				IVAL DATE	CHONEA
STATEMENT AND PLAN O	OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01		SURVEY PLETED
		445154	B. WING			04/3	30/2018
	PROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC		93:	REET ADDRESS, CITY, STATE, ZIP CODE 2 BADDOUR PARKWAY EBANON, TN 37087		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
K.741	Continued From parinternational symbol (2) In health care of prohibited and sign major entrances, so that prohibits smok (3) Smoking by patresponsible shall be (4) The requirement where the patient is (5) Ashtrays of non design shall be prosmoking is permitte (6) Metal container devices into which be readily available permitted. 18.7.4, 19.7.4 This REQUIREME by: Based on observation on 04, the improper disposed of in the indications:	age 6 of for no smoking. ccupancies where smoking is are prominently placed at all econdary signs with language ing shall not be required. ients classified as not e prohibited. It of 18.7.4(3) shall not apply a under direct supervision. Icombustible material and safe vided in all areas where ed. Is with self-closing cover ashtrays can be emptied shall to all areas where smoking is In the facility failed to a regulations. In the facility failed to a regulation of the facility dining room a room 114	K	741	1. Corrective Action: The metal ash content the patio outside the quality dining and outside exit by room 14 were and replaced with a more appropriately appropriately. The cigarette butts were removed from sidewalk and near combustible beto outside of the exit by room 117. A and/or Nurse Educator inserviced a proper disposal of cigarette butts, and/or Nurse Educator mailed letter family members educating them of proper disposal of cigarette butts, were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the disposal of cigarette butts. Were posted at exits near the affected areas if potential to be affected. 3. Measures or Systemic Changes: Maintenance Director or designee audit the smoking areas and exit a daily for 4 weeks and then weekly months. 4. How corrective action will be more than the month of the Maintenance Director or designee at Stand Up meetings to determine if any violations or conwere identified. The ADM or designee at Stand Up meetings to determine if any violations or conwere identified. The ADM or designee will review weekly for 4 weeks and then weekly for 2 months. The Adesignee will review the audits and findings to the QAPI committee. Committee will review the results QAPI meeting to ensure the POC of the posterior of the posterior of the POC of the posterior of the posterior of the POC of the P	room removed: resorution removed: remov	5723/18
	Maintenance staff	was present when these			effective and if any further correct action is warranted.	.¢.i∨∀	

May. 23. 2018 2:28PM Quality Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 43()9 F. 48/5()
PRINTED: U5/U3/2018
FORM APPROVED
OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	E SURVEY PLETED
		445154	B. WING		04/3	30/2018
	PROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC	9:	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 741	Continued From pa deficiencies were id acknowledged thes conference on 04/3	dentified and the Administrator se deficiencies during the exit	K 741			
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May. 23. 2018 2:03FM

Quality Center

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PRINTED: 05/03/2018	6
FORM APPROVED	
OMB NO, 0938-039	1

DEPARTMENT OF HEALTH AND HUMAN	SERVICES
CENTERS FOR MEDICARE & MEDICALD	SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING_

(X3) DATE SURVEY COMPLETED

445154

B. WING

04/30/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY

	Y CENTER FOR REHABILITATION AND HEALING LLC		EBANON, TN 37087	0.6
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000	, ý	
E 024 SS=C	A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 03/20/2018. During this Emergency Preparedness Survey, Quality Center for Rehabilitation and Healing was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by: Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024	2. Identifying other residents with potential	5 23 19
**	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of		to be affected: The facility determined all residents have the potential to be affected during an emergency. 3. Measures or Systemic Changes: The facility Emergency Preparedness policy was revised with regards to the use of yolunteers in an emergency or the use of	
	this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]		other emergency staffing strategles including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	
	(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCls at §403.748(b):] Policies and		4. How corrective action will be monitored: The ADM or designee will review the revised policy with the IDT. The ADM or designee will complete a response to the QAPI committee. The QAPI committee will review the revised policy at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	

Administrator

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN9505

if continuation sheet Page

May, 23. 2018 2:03FM Quality Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 43(9) F. 4()
PRINTED: 05/03/2018
FORM APPROVED
OMB NO. 0938 0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				E CONSTRUCTION (X3)	COMPLETED	
		445154	8. WING		04/30/2018	
	PROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC	223			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
E 024	emergency and of strategies to addre emergency. This REQUIREME by: Based on intervie policies and procein the emergency requirements of Figure 1.	ne use of volunteers in an her emergency staffing ess surge needs during an ENT is not met as evidenced w, the facility failed to include dures for the use of volunteers preparedness program per the ederal CFR §483.73.	E 024			
	the facility had no procedures for the emergency or oth strategies, includir integration of State	n/2018 at 12:20 PM, revealed record of polices and use of volunteers in an er emergency staffing and the process and role for and Federally designated isionals to address surge needs				
	This finding was v during the review preparedness pro	erified by the administrator of the facility's emergency gram.		10 to		